STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING 01 B. WING _____	02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SUMMIT CITY	2940 N CLINTON ST FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

RECEIVED
MAR - 4 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

Survey Date: 02/15/11

Facility Number: 000079
Provider Number: 155159
AIM Number: 100266160

Surveyor: Amy Kelley, Life Safety Code Specialist

At this Life Safety Code survey, Waters of Summit City was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This two story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridor. The facility has a capacity of 88 and had a census of 71 at the time of this survey.

Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/16/11.

The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:

Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.

This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is March 1, 2011

K 18

It is the intent of the facility to ensure that corridor doors can close and latch into the door frames.

Corrective Action
Room 126 door latches into door frame.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2/22/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APPROVED
3/8/11 AT

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K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 12 corridor doors on A hall closed and latched into the door frame. This deficient practice could affect any of the 9 residents on A hall. Findings include: Based on observation with the Maintenance Director on 02/15/11 at 12:45 p.m., the corridor door to storage room 126 failed to latch into the door frame. This was acknowledged by the Maintenance Director at the time of observation.	K 018	**Identification and corrective action taken for other residents potentially affected** 100% of all other doors have been reviewed with no other concerns. **Measures/Systemic changes made to ensure that the deficinet practice does not recur** Maintenance Supervisor/Designee will monitor function of latched doors weekly for 90 days then monthly as part of the preventative maintenance program. **Monitoring of corrective action to ensure the deficient practice will not recur** Weekly for 90 days then monthly monitoring audits will be reviewed and any issues identified will be addressed immediately. Findings will be presented to the quarterly Quality Assurance. **Completion Date: March 1, 2011**	

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K 018	Continued From page 2 3.1-19(b)	K 018	K 046	
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 emergency lights of at least 1½ hour duration was tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on an observation with the Maintenance Director on 02/15/11 at 1:55 p.m., a battery operated emergency task light was observed at the emergency generator. Based on an interview with the Maintenance Director at the time of observation, there were no written records for monthly tests, or for an annual test of the battery operated emergency task light available for review.	K 046	It is the intent of the facility to ensure that battery operated emergency task lighting is tested monthly and annually. **Corrective Action** Battery operated emergency task lighting at the generator was tested. **Identification and corrective action taken for other residents potentially affected** Facility has one battery operated emergency task light at the generator, no other concerns **Measures/Systemic changes made to ensure that the deficinet practice does not recur** Maintenance Supervisor was inserviced on proper testing and recording battery operated task lighting to meet standards. Maintenance Supervisor/designee will check battery operated task lighting weekly for 90 days then monthly and annually as part of the preventative maintenance program.	

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K 046	Continued From page 3 3.1-19(b)	K 046	**Monitoring of corrective action to ensure the deficient practice will not recur** Weekly for 90 days then Monthly/Annual monitoring audits will be reviewed and any issues identified will be addressed immediately. Findings will be presented to the quarterly Quality Assurance.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Drill Report" with the Maintenance Director on 02/15/11 at 12:00 p.m., there was no record of a second shift fire drill for the second quarter of 2010. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review to verify this drill was conducted.	K 050	**Completion Date: March 1, 2011** K 050 It is the intent of the facility to ensure that fire drills are conducted quarterly on each shift quarterly. **Corrective Action** A second shift fire drill was conducted on February 22, 2011. **Identification and corrective action taken for other residents potentially affected** All other fire drills have been conducted timely and a preplanned fire drill schedule has been implemented.	
K 144 SS=F	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144		

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K 144	Continued From page 4 accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid petroleum products at atmospheric pressure b) Liquifed petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:	K 144	**Measures/Systemic changes made to ensure that the deficit practice does not recur** Maintenance/Designee will conduct preplanned fire drill according to schedule to meet standard **Monitoring of corrective action to ensure the deficient practice will not recur** Fire drill reports will be reviewed and any issues identified will be addressed immediately. Findings will be presented to the quarterly Quality Assurance. **Completion Date: March 1, 2011** K 144 It is the intent of the facility to ensure that the off site fuel source for the emergency generator is from a reliable source and that the generator is equipped with a remote manual stop. **Corrective Action** Letter from gas company received and a remote manual stop was installed by a licensed contractor on 2/24/2011	

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K 144	Continued From page 5 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director on 02/15/11 at 2:00 p.m., the fuel source for the emergency generator was natural gas. Based on an interview with the Administrator and Maintenance Director on 02/15/11 at 11:50 a.m., the facility could not provide a letter from their natural gas provider stating the fuel source for the generator is a "reliable source." 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at	K 144	**Identification and corrective action taken for other residents potentially affected** Facility has only one generator. **Measures/Systemic changes made to ensure that the deficit practice does not recur** Maintenance/Designee will inspect the remote manual stop. **Monitoring of corrective action to ensure the deficient practice will not recur** Remote manual stop will be reviewed and any issues identified will be addressed immediately. Findings will be presented to the quarterly Quality Assurance. **Completion Date: March 1, 2011**	

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K 144	Continued From page 6 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director on 02/15/11 during a tour of the facility from 12:05 p.m. to 2:45 p.m., the facility did not have a remote manual stop for the emergency generator. Based on an interview with the Maintenance Director at 12:30 p.m., the generator motor was over 100 horsepower motor. 3-1.19(b)	K 144		